‘Health Communication Strategies under National Health Mission in Chhotaudepur District of Gujarat State’

A

Synopsis

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INTRODUCTION AND JUSTIFICATION

1.1 Introduction and Justification of Study

Health communication is an applied area of study concerned by the roles performed by human and mediated communication in health care delivery and health promotion. It is not limited to checking the pragmatic influence of human communication on the provision of health care and promotion of public health, but further also to enhance their quality.

It can be inferred that health communication is mostly problem – based, aiming at identifying, examining and solving problems related to health care and its promotion among larger public.

Concept of Health Communication evolved almost past three decades. It has received recognition among international scholars, policy planners and practitioners ranging from communication and mass media, sustainable development, public health, sociology, psychology, epidemiology *etc.* for their local and large-scale development programmes, researches and academic upgradation.

However, same is not observed and true to Indian scenario. Only countable / A very few of the researches have paid their attention towards Health Communication and Indian Health Programmes catering to Health concerns of second largest populated country on the world map.

Therefore, the presents research was planned initiate research efforts in this neglected area of knowledge. To gather insight into the ground realities related to Health Communication, it's Strategies, Provision, Usage, Barriers, Benefits and additional felt needs, the present research is planned.

The National Health Mission envisages achievement of universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs. The one of the main programmatic components include Health system strengthening, among others viz; Reproductive – Maternal – Neonatal – Child and Adolescents Health (RMNCH + A), Communicable and Non – communicable Diseases.

The Health system lies on both human and Non-human resources spread from top to grass root level.

In such a massive public health programmes human resources by means of using supportive non – human resources - infrastructure provides health services and promote health / healthy behaviours among public.

Health Communication is an essential integral ingredient in health service delivery and promoting desired behaviours using various Health Communication Strategies like Interpersonal Communication (IPC), mid media and mass media channels.

The past models of health care programmes like had different perspectives and hence different communication approaches used to achieve the targets. The National Health Mission has adopted, decentralised PPP model for its implementation up to grass root level.

The ministry has designed a strategic framework for targeted IEC activities using 360 – degree communication approach. The year – long plan has month-wise focus on health days and health themes (Chapter-27, NHM Annual report 2018-19, pp. 361).

Under the strategic component communication, several MOUs and tie-ups have been established for effective inter-sectoral convergence and greater possibility of achieving aims on health indicators through communication such as agencies at national and local level like, Directorate of Field Publicity (DFP), Print, Television – Doordarshan (Prasar Bharti), Radio, Outdoor publicity, Directorate of Advertising and Visual Publicity (DAVP), Social media platform and participation in events like Vibrant Gujarat Global Trade Show 2019. A huge amount of budget is allocated for the same.

The strategic communication plan is basically to strengthen and facilitate the work performance of health service providers based / Station at facilities (Doctor, Nurse, Pharmacist *etc.*) or on fields (ASHA, ANM, AWW *etc.*). The objective of IEC is to generate demand for health services and to promote health seeking behaviours. The different strategies has catered to the different needs of rural and urban masses through different modes of communication, be it Interpersonal Communication, Mid-media or Mass media activities.

The present study aims at preparing a profile of Health Care System with special reference to Health Communication component of National Health Mission at Chhotaudepur district, Gujarat State.

The investigator could find a very few empirical research evidences viz; Nongmaitthem, R. (2014) "A study of RCH communication: A critical analysis of NRHM, Manipur', Thakur, Jaiswal and Grover (2017) 'Is focus on prevention missing in National Health Programmes? A situational analysis of IEC / BCC / Health Promotional Activities in a district setting of Punjab and Haryana' and Tripathy, T., Singh, D., Tripathy, A. and Dwivedi, R. (2018), 'Use of IEC materials by ASHAs during Home Visit to disseminate Newborn Care Messages in Uttar Pradesh.'

The studies highlighted on serious loopholes in availability, provision / supply chain managements, use, barriers faced by the health functionaries and lack of absence of motivation, monitoring and evaluation of use of Health Communication strategies by the seniors. In addition to it, Thakur, Jaiswal and Grover (2017) reported that 'IEC / BCC / HP - is a neglected area in the selected districts with adequate infrastructure and human resources and poor programme implementation and requires strengthening for better implementation of the national health programme.

Moreover, such an important data with regards to use of IEC are rarely available even in large scale surveys like National Family Health Survey (2015-16)

NITI Aayog, Strategy for New India@75 (November, 2018), Chapter-27 Public Health Management and Action, embraces upon way forward to mobilise public health action at multiple levels by strengthening the Village Health Sanitation and Nutrition Day platform to cover a broader set of health issues across various population groups instead of only focusing on child health.

- Active multiple channels (Schools, Colleges, women's groups, traditional events like fairs, social media platforms, National Cadet Corps *etc.*) and prepare communication materials for catalysing behavioural change towards greater recognition of preventive health care.
- Make nutrition, water and sanitation part of the core functions of Panchayati raj institutions and municipalities.

Hence the most important carriers of health information *i.e.* the IEC/ICT/BCC strategies from the health planners to that of grassroots, needs to be paid utmost attention. Country need expediated efforts with regards to planning need based effective Health Communication Strategies, its proper flow to the health workers, and also efficient system to monitor and evaluate its usage related issues and challenges for appropriate results.

1.2 Justification of the study in context to the Department of Extension and Communication

The Department of Extension and Communication plays active and efficient roles as prescribed by the University Grants Commission (UGC) in all three areas concerned with Higher education *viz.* Teaching, Research and Extension.

The department is involved in disseminating knowledge on the applied, core and allied of concepts on Extension and Communication focusing not only theoretical understanding but offering practical experiences, skills related to selecting, designing and using appropriate communication strategies for the priority-based development issues. Therefore, the department curriculum includes courses like, Extension methods and materials, Communication Media for Development, IEC for development, Basics of Development Communication, Writing for Development, Software in Print Media, Software in Electronic Media, Software in folk Media, Communication for Development, Social and Behavioural Communication, Development Communication, Communication theories *etc.* Further, curriculum revision is a regular feature in the department.

The study with its elaborative as well as in-depth findings may contribute to the curriculum designing and updating as per the prevailing current trends in the society and development sector.

Findings of the investigation may provide evidence-based experiences for designing various training programmes, capacity building workshops for the health care providers highlighting the proper usage of various IEC and ICT materials while catering to the various developmental issues.

These activities can be very well undertaken in the both urban and rural outreach programmes. To carry out systematic outreach programmes by both Undergraduate and Post Graduate programmes is a routine identical feature of the department which has help earn respect in the field of development programme for need based planning, effective execution and systematic evaluation. Thrust areas like health-specifically reproductive health, adult and non-formal education, environment education, value education, skill development *etc.* catering to women, children, adolescents, school teachers, community health workers *etc.* are taken up regularly. In past department had collaborated with government and Non-Government Organisations for the several such development programmes. Department can create/provide a platform to share such knowledge while organising need based and pertinent seminars and workshops for communication media planners, practitioners, academicians, public health educators and public health providers.

Apart from this, in totality the department is actively engaged in research in the field of Extension and communication. In past department has undertaken some studies and action projects on various government efforts pertaining to programme appraisal, skills development

etc. on Right to Education, Integrated Child Development Scheme (ICDS), Indira Aavas Yojana *etc.*

However the present investigation would be a torch bearer study with the conceptual framework of Health Communication and National Health Mission in tribal district of Chhotaudepur. The study would throw light on various emerging areas of research related to Health Communication Strategies, availability, use, barriers, needs for diffusing relevant specifically Health and which are broadly applicable to behavioural change and developmental messages too.

Hence the present study may be contributory in the three well laid dimensions of higher education *i.e.* teaching, research and extension and is justified in context to the department of Extension and Communication.

1.3 Justification for selection of Locale of the Study

Tribal population in India is undergoing demographic, socio-economic and health transformation besides other indictors resulting to changes taking place at global level and in India too. This is applicable to Chhotaudepur district too. On 15th August 2013, Chhotaudepur was carved from Vadodara district for ease of administration for bureaucrats and government programmes.

The Chhotaudepur district is one among the 14 tribal districts of Gujarat, constituting 33 districts in total. The district shares border with Madya Pradesh and Maharashtra. The major tribal population inhibits in rural and forest area; the habitats are mostly amidst natural set up surrounded by jungles, water resources and small mountains.

Narain, J. P. (2019) in his editorial article, stressed on urgency of research in tribal area. 'At present national data are scant thereby providing a fragmented picture of tribal health and obscuring tremendous diversity among tribal groups scattered across the country. Disaggregated data by specific tribal groups and assessing the health, cultural and economic determinants of health, is therefore, urgently needed. Such research data will have a crucial role in designing and initiating evidence-based health policies, strategies and public health action suited to their unique social, cultural and geographical environment.'

Decentralised planning and implementation of National Health Mission is a core value of overarching nationwide programme.

Ministry of Health and Family Welfare and Ministry of Tribal Affairs, Report of the expert committee on tribal health, tribal health in India: Bridging the gap and roadmap for the future-Policy brief (2018), elaborates that 'Health literacy is low among tribal population. Since, knowledge is the best pill and vaccine, a massive health literacy drive for continuous health education of women, men, youth and children is a cost-effective intervention. Some health literacy strategies are targeted mass communication (wall paintings, posters and media); health science exhibitions on mobile vans eg. 'video rath'; folk media (folk theatre, street plays, cultural groups, health education courses and activities at schools; every contact with health system (ASHA, ANM, PHC, MMU) must be accompanied by a five-minute health education; information Technology (tablets, mobile phones, village volunteers and VHSNCs).'

Further the same report further noted significance of BCC campaigns and research while achievement of Objective 3, *i.e.* to empower the tribal people to adopt health practices to enhance their capacity for self-care.

Design effective Behaviour Change Communication campaigns.

a) The promotion of healthy behaviours requires formative research with ethnographic inputs to feed into health education and communication strategies; and to define the content of the communication.
b) Health campaigns must necessarily mix a strong endorsement of good practices inherent in tribal cultures- with a reasoned and sensitive disavowal of harmful practices.
c) All BCC strategies must recognise the heterogeneity of tribal groups and the need for tribe and region-specific interventions, in the local language and dialect.

Almost all researchers (mentioned in Chapter 2-Review of literature) noted the need and significant of culture specific, need and evidenced based, comprehensive and coordinated empirical data and thereby development and roll out of tailored Health Communication Strategies. In case of Health Communication Strategies under National Health Mission there exist immense dearth and hence significant scope of present research in tribal dense Chhotaudepur district of Gujarat state.

Researcher's inclination towards health communication study and personal concern for tribal population were added reasons besides above described points of rationale for selection of Chhotaudepur district as locale for the present enquiry.

1.4 Justification of samples of the Study

Sullivan T. M. et al. (2012) noted that 'an adequate assessment of health information needs, including opportunities, barriers and gaps is necessary for designing effective communication strategies and producing actionable information.'

Comprehensive communication strategy adopted with a strong behaviour change communication (BCC) component in the IEC strategy; dissemination in villages and lowest levels. There is participation of non-government agencies and professional and specialized agencies, visible mass media efforts in massive health communication efforts. There is a substantial portion of the interpersonal BCC effort is through local ground level workers including ASHA and ANMs, and community level structures equipped with communication kits, interacting on a one to one basis with families. (NHM, Manual for District level Functionaries, 2017)

NHM has a well-defined implementation framework up to grassroots. In such a framework the vertical and horizontal flow of communication plays very crucial role and thereafter contribution made by each official and health worker. A huge amount of budget is allocated for achieving health behaviours and thereby improved health status of all sections of society through the ASHA programme under NHM; it becomes essential to check proper utilization of the resource vis a vis the health status of the people.

Few studies could be found on exploration of role performance and service delivery functions of health workers in India. There is a dearth of researches with reference to provision, use and perceived benefits of Health Communication Strategies expressed by the key health functionaries (ASHA, ANM/FHW and ASHA Facilitator). The researcher did not want to leave a single stone unturned while measuring the status of Health Communication under NHM in Chhotaudepur, tribal area. Therefore, it was decided to select samples from majorly all grassroot level health functionaries to understand the Health Communication component properly.

The study may highlight the various hurdles / barriers related to Health Communication Strategies if any by them. This may help in eradicating the felt barriers and bringing change in designing, distributing policies of the health communication system used under NHM. This in turn may help in increasing the effectiveness of health communication efforts in the selected tribal district- Chhotaudepur.

1.4.1 Justification for Selecting the ASHAs:

ASHA being the grassroot level health activist under NHM, her responsibility as Link worker, mobiliser and service provider using Inter personal communication approach with beneficiaries and health care machinery is very crucial and significant.

ASHAs are first port of Information and health care needs. She has to actively work in coordination with AWW and ANM/FHW for organizing and celebrating some special days in communities like *Mamta* Day, Village Health and Sanitation days *etc.* She has to imbibe better health care behaviour amongst community people specifically vulnerable groups like women, adolescents, new-borns, children and old age people. ASHA has been assigned many responsibilities to provide health care facility at household level.

To be able to perform all her assigned roles, ASHA has to be an effective Health communicator. Therefore, it was felt necessary to study different strategies used while performing her prescribed roles.

On supply side she should be able to provide correct information and treatment to beneficiaries. While attending to queries during ANC visit, pregnancy complications, Home Based New-born Care, Initial Breast-feeding practice *etc.* She should be able to guide and counsel in a most appropriate way.

In some places NGOs are working in close partnership with government NHM programme. They have provided ASHA with some IEC materials in their areas and in some parts of the state ICT based devices like Handheld device, PDAs and mobile facilities are given on experimental basis.

Government of India has also developed a separate IEC department under NHM which is responsible for designing general BCC/IEC materials for all over India. However, states are given responsibility to adopt and modify those IEC/BCC strategies as per local applicability and requirements.

There is a provision of State Level guiding Resource centre to facilitate the ASHA programme. Immediately after selection ASHA undergoes rigorous straining. She is also trained to use Communication to promote behaviour change. Therefore, the present study is well justified in terms of adoption and benefits perceived of the Health Communication strategies by ASHA workers to perform her roles.

The present study attempts to check the availability of communication strategies with ASHA workers. It further aims to identify needs and requirements related to Health Communication strategies be it IEC (Chart, Poster, Cards, flipbook, booklet *etc.*) Mass Media (Radio, TV, Newspaper, Magazines, Hoardings/Banners, Wall painting *etc.*) ICT (Computer, internet, handheld devices, Mobile and smart phones *etc.*) to perform roles of ASHA as key health worker, Behaviour Change agent, Record keeper and Key informant. There are evidence gaps with respect to the extent to which ASHAs can be health activists or agents of change, supporting community participation and empowerment which are crucial aspects of health improvement and sustainability in context to her use of Health Communication Strategies. The study would be able to provide a guideline for proper planning and utilization of budget allocated for communication on most appropriate tailor-made model and theories of Development Communication and Health Communication in particular for ASHAs under NHM.

1.4.2 Justification for Selecting ASHA Facilitators:

According to ASHA programme guidelines, there would be one ASHA facilitator for every 10-20 ASHAs, as the first level of support. The ASHA facilitator is involved the selection of the ASHA.

ASHA facilitators main roles comprised of monthly review meetings, respond to grievances, maintain records of ASHA activities, attend Village Health and Nutrition Days with the ASHAs, and attend monthly block PHC centre meetings. Very important role is to support ASHA to promote healthy behaviours and improve service access among difficult families during household visit.

During the course of study, it may also bring to the notice the responses expressed by the ASHA Facilitators while with regards to selected aspects related Health Communication Strategies (provision and use) for promoting desired behaviours. Systematic study of barriers may help development and health care planners to make alternation or improvement in the present communication strategies for future use.

1.4.3 Selection of Female Health Workers:

The Female Health Worker is based at Subcentre, which is the first level of the health system. So, her role is very crucial for stepping in patients at the subcentre. Moreover, she is also responsible to convene Village Health Nutrition Day in a village, which is a monthly activity

wherein she carries out vaccination and provides ANC services, conducts counselling session and contraceptive services to eligible couples.

So overall, VHND provides a good scope for mobilising beneficiaries for adapting key health messages though effective use of Health Communication Strategies.

Female Health Worker also has to attend monthly meeting of Village Health Sanitation and Nutrition Committee as a member, convened by the ASHA as a secretary. There also she can sensitise and put forth her opinions on agenda concerned to social-cultural and environmental determinants of health.

Therefore, it is significant to find out provision, availability, use and barriers related health communication approaches at Anganwadi on VHND and during meeting of VHSC (mostly at Panchayat office).

In recent past, Female Health Workers are armed with TeCHOmobile – a smart phone. It is a new technology lead initiative of health department for robust management of data and health information. Female Health Workers also called as FHWs (Female Health Worker) are responsible for collecting and maintaining data from ASHAs and ASHA Facilitators. Further they have to coordinate with PHC level staff for data entry and retrieval. Since it a transition phase, they have to maintain registers, entre data in e-*Mamta* portal and TeCHOmobile too. The findings of the present study may throw light on the experiences of ANMs while using new technology, which may give a guideline for further implementation of new technology for all other frontline Health Functionaries (ASHA, AWW and ASHA Facilitators)

Hence selection of FHW as one of the samples is justified in the present study, which is focused on selected aspects of various Health Communication Strategies for delivering the Health messages and performing various preventive and curative roles and responsibilities.

1.5 Justification for selection of Variables of ASHAs:

In the present research enquiry, the ASHAs are selected as a key sample for both qualitative and quantitative data. Following points highlight upon justification of personal characteristics/variables of ASHAs, selected under the present study.

1.5.1 Block:

The Chhotaudepur district has six blocks in its revenue boundaries. Block Health Office, headed by the Block Health Officer serves as a coordinating link between PHCs and District

Health offices for implementation of all health programmes and distribution of required resources.

Health Communication Strategies provided by District level office would be channelized by BHO and distributed upto PHCs. Further the respective PHC distribute them into 2-3 part, one for frontline functionaries (ASHAs, ANM, ASHA Facilitators and AWW), second for display and use at PHC and other health facilities and third for display and distribution in communities and other public places. The Provision of Health Communication resources and materials is based on demand from the block and also on the supply from state health department in line with available budget.

Apart from this, each block varies with respect to geographic, demographic and cultural characteristics which effect to their health indictor, although the whole district is dominated with tribal population. ASHAs belonging to different block may have different say with regards to Health Communication Strategies and its selected aspects *viz.*, provision, use, perceived benefits, barriers and need. Therefore, it was felt necessary to study block-wise variation amongst the ASHAs for the selected dependent variables of the study.

1.5.2 Age:

Age is generally linked with individual's maturity and capability to handle the situations. With the growing age, an individual gathers more experiences in life. More matured individual would be in a better position to handle situations at personal and professional fronts. Age of a person may affect his/her readiness to adopt the changes occurring at home and at work place and expected to handle them. There may be high possibilities that an older individual may behave more reluctant, hesitant and younger may be curious, motivated and more adaptive towards communication aspect of National Health Mission.

The ASHAs are envisaged with multiple roles where she would come across variety of people in different set ups handling challenging tasks.

Crispin, N. et al (2012) in their study related to Community Health Workers, found significant relationships of age with good record keeping ($p = 0.0001$), appropriate use of job aids ($p=0.0001$), client satisfaction ($p = 0.018$) and client enablement ($p = 0.001$).

Bajpai and Dholakia (2011) observed significant differences among older and younger age groups of Female Health Workers in Karnataka for using mobile phone for their job, older used less as compared to younger.

The Age of an ASHA may act a significant factor for being able to carry and use the Health Communication Strategies for performing responsibilities.

The ASHAs may differ with respect to their age for her responses regarding perceived benefits, barriers and additional needs regarding Health Communication Strategies.

Therefore, it was decided to take age as one of the variables under the study.

1.5.3 Education

Education provides knowledge of the world around. Education develops in us a perspective of looking at life. It helps us build opinions and have points of view on things in life. An individual can bring changes among society to lead a letter life.

The ASHA possessing higher educational qualification may have different perspective than her counterparts. Higher education status may lead ASHAs to perform her duties in a better way.

Sharma, Webster and Bhattacharya (2014) have recognized that the education of ASHA affected her motivation and performance.

According to ASHA programme guideline minimum qualification required for the appointment is qualifying primary schooling (Standard 8^{th}), however in difficult areas the authorities may have some flexibilities.

The selected ASHAs under present study belonged to the tribal area. Their education level may revel differences in her understanding about health concerns of her community people. Her orientation towards health issues and understanding for the situation along with her own perception may affect her service delivery and health promotion. *Education* empowers minds that will be able to conceive good thoughts and ideas.

The ASHA may have devised ways of communicating with people and healthcare staff. Her education may influence her choice of communication strategies, use, barriers and perception about benefits of Heath Communication Strategies. Hence, it was felt necessary to study this variable by the researcher.

1.5.4 Work experience:

Experience is considered the best teacher in life. What an individual learns and experiences can often determine his/her success or failure in life. Effortful learning combined with real life on the job experience is a winning formula for success. ASHAs are dedicated individuals who function along a continuum ranging from individual and community to service delivery and promoting community empowerment and social justice. They help link people to needed health care information and services.

Repeated and long-time of same work make the person more efficient and competent; on the other side it may lead to monotony and boredom. Wheras individuals with less experience may feel lost, hesitant, need assistance *vis-a`-vis* open to experimentation, motivated.

Findings of Siribie et. al. 2016 can provide support to it, that young, single, new CHWs performed better than their old, married, more experienced counterparts.

ASHA's appointment is done locally-in her own village (ASHA programme Guideline, 2005). Working with the same community people, will fetch her proper understanding about determinants of health in her area. Comparatively long years of experience for ASHA may determine her set adoption to job aids on the contrary newly joined ASHAs may be open with variety and trail of job aids.

It is one of the variables which is most studied by the scholars with reference to work performance, however availability of few evidences with regards to work experience and selected aspects of Health Communication Strategies motivated the investigator to include it in the present study.

1.5.5 Occupational skills:

Occupational skills- is a component of ASHA training module-5. Five soft skills desired for her occupation viz, communication, coordination, leadership, negotiation and decision making are included. Development of these skills would enable the ASHA to work at her maximum potential during interpersonal, group interaction and mobilising the villagers for achieving goals of health. The ASHAs can be effective and efficient in her work who own better occupational skills than her counterparts.

Following research findings prove that the occupational skills are important for the ASHAs. Personality traits and skills like communication, motivation, leadership and ability to reach out to community members are also important factors shaping the effectiveness of CHWs (Saprii et. al. 2015)

Garg, P.K., Bhardwaj, A., Singh, A., Ahluwalia, S. K. (2013) 'ASHAs need to improve on negotiation skills while dealing with poor women and children.'

Occupation skills often direct ASHA for her communication approach. She would be more confident, clear and assertive in her discourse on health behaviours amongst community. It is assumed that she may be able to handle various media effectively. Those owning higher level of occupational skills may have better clarity about use, effectiveness and requirements of Health communication tools to facilitate her roles, in addition, it is imperative that she may be able to reflect upon barriers related to Health Communication Strategies.

Health Communication strives to bring desirable behavioural change through promotion of health awareness and provision of health benefits to all beneficiaries. It has close connection with the occupational skills of the ASHAs. Therefore, ASHAs' occupational skills and her responses related to provision, use, barriers, benefits and need of additional Health Communication Strategies in Chhotaudepur under NHM may have significant importance in deriving its overall status.

1.5.6 Training received under NHM:

Training is an integral and ongoing component of the ASHA programme. As mentioned in ASHA Guideline, Capacity building of the ASHA is critical in enhancing her effectiveness. Capacity building of ASHA has been seen as a continuous process, to begin with induction training, periodical training and on job training. There are total seven modules and a refresher course are planned for the ASHAs under capacity building programme. It has been envisaged that training will help to equip her with necessary knowledge and skills resulting in achievement of scheme's objectives and ultimately NHM's goals. Following research evident describe significance of training on ASHAs.

Garg, P.K., Bhardwaj, A., Singh, A., Ahluwalia, S. K. (2013) concluded that ASHAs were satisfied and happy with the training but their perception about the in-job responsibilities appeared to be incomplete and improper. Many of them were not aware about their role in assisting ANM in village health planning, creating awareness on basic sanitation and personal hygiene, birth-death registration. Incentives in monetary terms and capacity building in the weak areas of training can act as delivering better health services.

Similar findings were recorded by Gosavi and et. al (2009), 'lack of good training and poor clarity on how to collaborate work with the ANM and AWW.'

This study showed that an ASHA's motivation and performance are affected by a variety of factors; personal (e.g. education), professional (e.g. training, job security), and organisational (e.g. infrastructure) along with others that emerge from external work environment. (Sharma, Webster and Bhattacharya, 2014)

Further, it was assumed that the trained ASHA may be using a greater number of Health Communication Strategies as she has good command over them whereas it may be equally true for the ASHA having incomplete training and trying her hands on variety of Health Communication Strategies.

1.5.7 Knowledge regarding Health Communication Strategies:

Knowledge is a key to empowerment, as it is understood generally. Knowledgeable person has a capacity to take wise decision by application of the knowledge to the situation.

As per ASHA guideline, the ASHAs are trained for performing her assigned tasks. Their training programme is such where trainers and facilitators use various techniques and media of teaching, training and counselling. On induction the ASHAs are provided with ASHA kit which includes, ASHA Diary, Health Card (*Mamta* Card) and registers. Besides this during weekly PHC meetings ASHAs may be exposed to charts/ posters, counselling cards, flipbook, leaflet, booklet, power point presentations, Television *etc.* and supportive mass media campaign through wall paintings/wall writings, chat/poster, radio spots, television advertisement *etc.*

Not only this, ASHAs might be taught about the method of using different media in individual, group and mass set up. Therefore, it is assumed that ASHAs would have knowledge about various communication strategies.

Bhattacharyya, K., et. al. (n.d.) reviewed how the use of multiple incentives can contribute to CHW retention in which they mentioned about Identification (badge, shirt) and job aids (Nonmonetary factors) as CHW Incentives.

Community Health Worker Trainer's Manual: A Guide to Home-Based Services, Columbia University, (2013) Relevant CHW job aids and counselling cards for each participant, participant worksheets and answer keys, necessary materials (e.g., handouts, visual aids, props) for practice activities, PowerPoint slides and audio-visual equipment are provided.

Brooks, B.A., et. al. (2014), Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, & Lower Costs Job aids (or tools) such as checklists, flowcharts, and educational materials, along with interview, assessment, and data collection forms, facilitate and organize the CHW's work.

The above paragraphs describe that since the ASHAs are exposed, provided and surrounded by many Health Communication approaches and strategies, they would possess knowledge about them and their contextual use in different conditions. The ASHAs with higher level of knowledge may know the appropriate use at individual, group and mass level for strategic objectives like awareness generation, counselling, behaviour change, mass mobilisation *etc.* Better knowledge level about Health Communication materials will offer a guideline to ASHAs and help shape her responses for use, effectiveness, barriers and needs of Health Communication Strategies in NHM.

Hence, the ASHAs may vary with respect to their level of knowledge about various objectives of Health Communication Strategies covered under the study.

1.5.8 Media use:

Media use of the ASHAs under study is with reference to her use of personal modes of communication and mass media. The ASHA is expected to be studied upto primary (8^{th}) level. It is possible that for keeping herself updated about latest news she may be reading newspaper, listening to radio or watching television. She may use all these mass media for her personal interests, recreation and entertainment too. These are also the ways through which she may want to keep updating her health-related knowledge.

Rapid growth of telecommunication and mobile phones may have been part of ASHA's family. It is a mean to stay connected with family members for the reasons of security and concerns besides, a mean to contact relatives, friends for maintaining family relations. This small device assists the ASHA to stay connected with health staff and with community/beneficiaries.

The investigator, hypothesis that the ASHAs with higher media use may use more communication strategies as they might have been benefited by them. ASHAs would better understand the importance of using various communication strategies to enhance on her efforts in behaviour change, promotion of health and health service delivery. In this process she might have faced some barriers with regards to availability, accessibility, infrastructure support from health department and factors related to beneficiaries, staff and her own capabilities. Her expectations in all these situations may differ with her own use and barriers felt for media at personal level/front.

Therefore, media use of ASHA- variable is also considered to be included in the present research on Health Communication Strategies under NHM in Chhotaudepur district.

1.6 Objectives:

1) To prepare **Profile of existing Health Facilities** in Chhotaudepur district of Gujarat state.
2) To study the **process of Health Communication Strategies** from Chief District Health Officer in Chhotaudepur district of Gujarat state.
3) To seek **recommendation for future Health Communication Strategies** from Chief District Health Officer in Chhotaudepur district of Gujarat state.
4) To prepare **Profile of the selected ASHAs** of Chhotaudepur district of Gujarat state.
5) To find out **Provision** of Health Communication Strategies available to the selected ASHAs in Chhotaudepur district of Gujarat state.
6) To find out **overall Use** of Health Communication Strategies by the selected ASHAs in Chhotaudepur district of Gujarat state.
7) To study the **differences in overall Use** of Health Communication Strategies by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
    a. Block
    b. Age
    c. Education
    d. Work experience
    e. Occupational skills
    f. Training received
    g. Knowledge regarding Health Communication Strategies
    h. Media use
8) To find out activity wise **Use of Health Communication Strategies** by the selected ASHAs in Chhotaudepur district of Gujarat state for the following activities:
    i. Home Visit
    ii. Planning and celebrating VHND (*Mamta day*)
    iii. Visit to Health Facilities
    iv. Village Health and Sanitation Committee Meeting
    v. Keeping and informing about records

9) To study **activity wise differences** in Use of Health Communication Strategies by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
    a. Block
    b. Age
    c. Education
    d. Work experience
    e. Occupational skills
    f. Training received
    g. Knowledge regarding Health Communication Strategies
    h. Media use
10) To study **Perceived Benefits** of Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state.
11) To study **differences in Perceived Benefits** of Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
    a. Block
    b. Age
    c. Education
    d. Work experience
    e. Occupational skills
    f. Training received
    g. Knowledge regarding Health Communication Strategies
    h. Media use
12) To find out **Barriers** related to Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state.
13) To study **differences in Barriers** related to Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
    a. Block
    b. Age
    c. Education
    d. Work experience
    e. Occupational skills

f. Training received
g. Knowledge regarding Health Communication Strategies
h. Media use

14) To study the **overall Need** of additional Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state.

15) To study **differences in Need** of additional Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
    a. Block
    b. Age
    c. Education
    d. Work experience
    e. Occupational skills
    f. Training received
    g. Knowledge regarding Health Communication Strategies
    h. Media use

16) To study **Need of additional Health Communication Strategies** expressed by the selected ASHAs in Chhotaudepur district of Gujarat state for the following activities:
    i. Home Visit
    ii. Planning and celebrating VHND (*Mamta day*)
    iii. Visit to Health Facilities
    iv. Village Health and Sanitation Committee Meeting
    v. Keeping and informing about records

17) To study **activity wise differences** in Need of additional Health Communication Strategies expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
    a. Block
    b. Age
    c. Education
    d. Work experience
    e. Occupational skills
    f. Training received
    g. Knowledge regarding Health Communication Strategies

h. Media use

18) To study **provision, use, perceived benefits, barriers and needs for additional Health Communication Strategies** expressed by the Female Health Workers and the ASHA facilitators in Chhotaudepur district of Gujarat state.

1.7 Null Hypotheses:

1) There will be no significant **differences in <u>overall Use</u> of Health Communication Strategies** by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
   a. Block
   b. Age
   c. Education
   d. Work experience
   e. Occupational skills
   f. Training received
   g. Knowledge regarding Health Communication Strategies
   h. Media use
2) There will be no significant **differences in <u>activity wise Use</u> of Health Communication Strategies** by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
   a. Block
   b. Age
   c. Education
   d. Work experience
   e. Occupational skills
   f. Training received
   g. Knowledge regarding Health Communication Strategies
   h. Media use
3) There will be no significant **differences in <u>Perceived benefits</u> related to Health Communication Strategies** expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
   a. Block
   b. Age

c. Education
d. Work experience
e. Occupational skills
f. Training received
g. Knowledge regarding Health Communication Strategies
h. Media use

4) There will be no significant **differences in <u>Barriers</u> related to Health Communication Strategies** expressed by the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
   a. Block
   b. Age
   c. Education
   d. Work experience
   e. Occupational skills
   f. Training received
   g. Knowledge regarding Health Communication Strategies
   h. Media use
5) There will be no significant **differences in <u>overall need of additional</u> Health Communication Strategies** among the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
   a. Block
   b. Age
   c. Education
   d. Work experience
   e. Occupational skills
   f. Training received
   g. Knowledge regarding Health Communication Strategies
   h. Media use
6) There will be no significant **differences in <u>activity wise need of additional</u> Health Communication Strategies** among the selected ASHAs in Chhotaudepur district of Gujarat state in relation to following variables:
   a. Block
   b. Age
   c. Education

d. Work experience
e. Occupational skills
f. Training received
g. Knowledge regarding Health Communication Strategies
h. Media use

1.8 Assumptions:

1. ASHAs, ASHA Facilitators and Female Health Workers of Chhotaudepur district are provided with various Health Communication Strategies for performing their roles as prescribed under NHM.
2. ASHAs, ASHA Facilitators and Female Health Workers of Chhotaudepur district will express their use, perceived benefits, barriers and need of additional Health Communication Strategies under NHM.
3. The Selected ASHAs may vary according to the selected variables for their use, perceived benefits, barriers and need of additional Health Communication Strategies under NHM in Chhotaudepur district of Gujarat State.

1.9 Delimitations:

1. The present study is delimited to the data received from District Panchayat Office, Chief District Health Officer, Female Health Workers, ASHA Facilitators and ASHAs from all six blocks, regarding selected aspects of Health Communication Strategies under NHM in Chhotaudepur District, Gujarat.
2. Responses of the ASHAs are delimited to use and need of additional Health Communication Strategies for prescribed Five activities (*i.e.* Home visit, planning and celebrating Village Health and Nutrition Day, visit to health facilities, Village Health and Sanitation Committee meeting and maintaining and informing records) in ASHA guideline, perceived benefits and barriers related to Health Communication Strategies.
3. Responses of ASHA facilitators and Female Health Workers are delimited to provision, use, perceived benefits, barriers and need of additional Health Communication Strategies.

METHODOLOGY

The present study was undertaken with the broad objective to study the Health Communication Strategies under National Health Mission in Chhotaudepur district of Gujarat state.

The study has been intended to draw attention towards Communication aspect of mission mode programme of health in India. The present investigation is a combination of descriptive and analytical methods to explore and describe the existing situation of Health Communication Strategies under NHM in the selected Tribal district of Chhotaudepur, Gujarat state. Following methodological steps were adopted to conduct the research:

2.1 Feasibility study

2.2 Selection of Area and Population

(A) Methodology for Survey

2.3 Sampling unit

2.4 Sampling frame

2.5 Sample size and selection techniques

2.6 Construction of the Research tool

2.7 Validity of the Research tool

2.8 Pre-testing and Reliability of the Research tool

2.9 Procedure of Data collection

2.10 Scoring and Categorisation of the Data

2.11 Plan of Statistical analysis of the Data

(B) Methodology for Focus Group Discussions and an In-Depth Interview

2.12 Sampling unit

2.13 Sampling frame

2.14 Sample size and selection technique

2.15 Research tools for Data collection

2.16 Process of Conducting FGDs and Interviews

2.17 Analysis and Interpretation of Data

2.18 Ethical aspects of the Research

2.1 Feasibility study

The feasibility study was carried out aiming at preparing profile of ASHAs and Development Communication Approaches used by them while performing their duties, in two districts, which were selected purposively *i.e.* Vadodara and Chhotaudepur. An In-depth interview schedule was developed. Data collection was done during June-July 2017 personally by the researcher. The ASHAs from these districts were approached through purposive and snow ball sampling techniques. The final sample consisted of 12 Urban, 9 Rural and 9 Trible ASHAs. Permission from respective district level health departments were taken in advance and ASHAs were asked for their consent to be part of the feasibility research.

The findings highlighted that ASHAs were performing their roles and responsibilities using limited communication materials/IEC strategies available with them. These IEC materials (*i.e.* Mamata card, *Mamta* diary and register) were provided by Government under NHM. ASHAs would be able to perform in a better way if provided with most suitable and appropriate Development Communication Materials to them for different content on health. This implies that ASHAs should be studied in terms of training received, provision, use, perceived benefits and barriers with reference to Health Communication Strategies. The ASHAs and other Health Care providers (ASHA Facilitators, Female Health Workers, Medical Officers, Block Health Officers etc) should be approached for their need and expectations for the type and variety of IEC.

Hence a need was felt for in-depth research to understand status of Health Communication Strategies in Chhotaudepur district in general and ASHAs in particular. Therefore, present research with its specific objectives (Refer Page no.) was undertaken.

2.2 Selection of Area and Population

Chhotaudepur in Gujarat is one of the 14 Tribal districts; situated in middle-east part. The selected tribal district is divided into six blocks namely Chhotaudepur, Pavi Jetpur, Kawant, Bodeli, Naswadi and Sankheda, here Chhotaudepur block act as district

headquarter. Therefore, ASHAs, ASHA facilitators, Female Health Workers (FHWs), Medical Officers, Block Health Officers (BHOs), District IEC officer and Chief District Health Officer from Chhotaudepur district of Gujarat state, comprised Population of the study.

Figure (Map):1 Chhotaudepur District, Gujarat State, Source:

(A) Methodology for Survey

2.3 Sampling unit

For the purpose of survey, ASHAs were identified as a primary sampling unit.

2.4 Sampling frame

In total 1102 ASHAs from Six Blocks of Chhotaudepur district constitute the Sampling Frame. For this, the researcher had personally collected block wise lists of ASHAs from the office of Chief District Health Officer, District Panachayat, Chhotaudepur.

2.5 Sample and Sample Selection Techniques

For the present research Multi-Stage sampling technique was planned to draw required sample.

At Stage-1, it was decided to take all six blocks to have complete overview of the tribal district of Chhotaudepur. The block-wise list of 45 PHCs along with 1102

appointed ASHAs were collected from District Panchayat Office, Chhotaudepur by the researcher herself.

Using Simple Random Sampling method, PHCs were selected from each block at stage-2. The researcher had followed ethical aspects of both means, those of health department, government of Gujarat and the Maharaja Sayajiro University of Baroda, Vadodara. Therefore, permission was taken from Family and Health care department, Government of Gujarat, Gandhinagar, Chief District Health officer, Chhotaudepur, and respective Block Health Officers for conducting this study.

Further, at Stage-3 ASHAs, were selected randomly from until the desires sample size was achieved.

Finally, in total 326 ASHAs were selected from the six blocks namely Chhotaudepur, Pavi Jetpur, Kawant, Bodeli, Naswadi and Sankheda of Chhotaudepur District of Gujarat state. It is described in figure:2

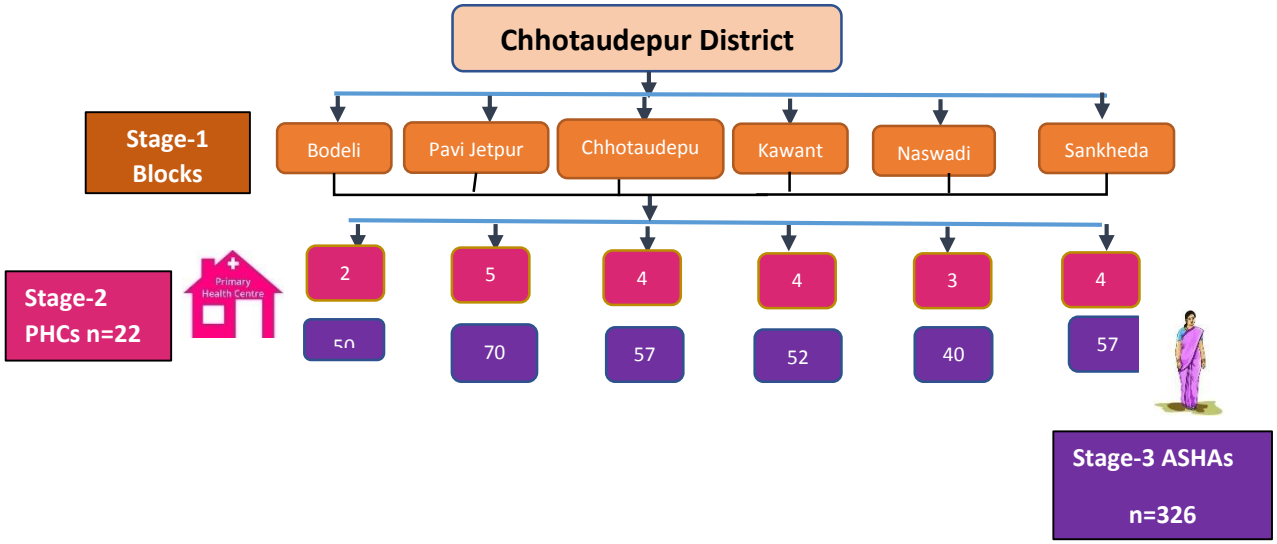

Figure: 2 Description of Final Sample

2.6 Construction of the Research tool

A questionnaire was designed for the purpose survey of ASHAs. The tool consisted of Five sections in line with the specific objectives of present research. It was primarily developed in English and then translated in Gujarati. Following table describes in detail the questionnaire used for the ASHAs:

Table:1 Description of Tool used for Survey

Part	Objective	Content	Tool
A.	To prepare Profile of the selected ASHAs	Personal information, Work-related information, Media Use Occupational Skills	Questionnaire & Information Schedule Rating scale
		Training received under NHM	Checklist
		Knowledge regarding Health Communication Strategies	Knowledge Test
B.	To find out Provision of Health Communication Strategies	Sources of Information	Checklist
		Provision of Health Communication Strategies under NHM	Checklist
	To find out Use of Health Communication Strategies	Use of Health Communication Strategies during; Home visit, Planning and celebrating VHND (*Mamta* day), Visit to Health Facilitates, Village Health & Sanitation Committee Meeting, Keeping and informing about records	Checklist
C.	To study the Perceived Benefits of Health Communication Strategies	Perceived benefits of Health Communication Strategies	Rating Scale
D.	To find out Barriers Related to Health Communication Strategies	Barriers Related to Health Communication Strategies	Rating Scale
E.	To study the Need of Additional Health Communication Strategies	Special Training received related to Health Communication Strategies	Checklist
		Need for additional Health Communication Strategies for; Home visit, Planning and celebrating VHND, Visit Health Facilitates, VHSNC Meeting, Keeping and informing about records	Checklist

2.7 Validity of the Research tool

The questionnaire was validated by the selected experts from allied fields. The validators were requested to review and give their comments as well as critical remarks for the content, framing of questions/statements, clarity of language and response system used in the questionnaire. The researcher incorporated suggestion in the research tool. However, no major suggestions were received.

2.8 Pre-testing and Reliability of the Research tool

The questionnaire was pretested with the ASHAs to check clarity of language (Gujarati) ,Response system and time taken for completely filling up the tool.

2.9 Procedure of Data collection

Block Health Officers and then Medical Officers were contacted for permission and to fix up meetings with ASHAs at the selected PHCs. ASHAs and ASHA Facilitators were contacted for deciding time. The ASHAs were informed about the objectives of research and importance of their participation and consent form. The questionnaire was filled up by the ASHAs in a group meeting with the assistance / help of the researcher. It took almost two hours on an average to completely fill up the tool. Data collection was done personally by the researcher from 326 ASHAs during February- April months of 2019

2.10 Scoring and Categorisation of the Data

2.10.1 Scoring and Categorisation of the Variables

Following tables describe scoring and categorization of the selected variables under study.

Table: 2 Categorisation of Variables of ASHAs under study

Variable	Basis	Range	Categories
Block	-	-	Chhotaudepur
	-	-	Sankheda
	-	-	Bodeli
	-	-	Nasvadi
	-	-	Pavi Jetpur
	-	-	Kavant
Age	Mean and Above Mean	35 to 62 years	Older
	Below Mean	21 to 34 years	Young
Educational Qualification	-	-	Primary
	-	-	Secondary
	-	-	Higher Secondary
	-	-	Graduation
Work Experience	Mean and Above	7 .1 to 15 years	More Work Experience
	Below Mean	7 years and below	Less Work Experience
Media Use	Above Mean	2.10 and above	High
	Mean	1.05-2.00 hrs	Average
	Below Mean	1.00 and below	Low
Occupational Skills	Above Mean	112 and above	Excellent
	Mean	98-111	Moderate
	Below Mean	97 and below	Poor
Training received	Completely trained for all modules with a refresher course	-	Completely trained
	Not received training for anyone/more modules or refresher course	-	Partially trained
Knowledge regarding HCS	Above Mean	13 to 20	High
	Mean	7 to 12	Medium
	Below Mean	1 to 6	Low

Table:3 Categorisation of other variables of the ASHAs

Variable	Basis	Categories
Marital status	-	Married
	-	Widow
	-	Divorcee
	-	Separated
	-	Unmarried
Caste	-	General
	-	SC
	-	ST
	-	OBC
	-	Others
Total Monthly Family income	5001 and above	High Monthly Family Income
	500 to 5000	Low Monthly Family Income
Number of Family members	6 and above	More number of Family members
	5 and below	Less number of Family members
Type of Family	-	Nuclear family
	-	Joint family
	-	Extended family
Number of assigned Villages	One (1)	One (1) village
	Two (2) and more	Two (2) and more villages
Population covered	1032 and above	Large population to be covered
	1031 and below	Small population to be covered
Number of Households in the assigned area	177 and above	More number of Households in assigned area
	176 and below	Less number of Households in assigned area
Number of Working hours	181 hours and above	More number of working hours
	180 hours and below	Less number of working hours

2.10.3 Provision and Use of Health Communication Strategies

2.10.3.1 Sources of Information

To measure the sources of information used by the ASHAs, a classified checklist was developed, wherein total 31 Health Communication Strategies were given in four categories viz, 14- Print and graphic media, 13- Electronic and new media, 3-Folk media and 1-others. Based on the number of Sources of Information used by the ASHAs, categorisation was done as follows:

Variable	Basis	Range	Categorisation
Sources of Information	Mean and Above	6 and above	More sources of Information
	Below Mean	5 and below	Less sources of Information

2.10.3.2 Provision of Health Communication Strategies under NHM

The same a classified checklist was used to check Provision and use of Health communication Strategies for selected work, wherein total 31 Health Communication Strategies were given in four categories viz, 14- Print and graphic media, 13- Electronic and new media, 3-Folk media and 1-others. Based on the number provision and use of Health Communication Strategies by the ASHAs, categorisation was done as follows:

Variable	Basis	Range	Categorisation
Provision of Health Communication Strategies	Mean and Above	11 and above	More provision
	Below Mean	10 and below	Less provision

2.10.4 Use of Health Communication Strategies

The same a classified checklist was used to check Provision and use of Health communication Strategies for selected work, wherein total 31 Health Communication Strategies were given in four categories viz, 14- Print and graphic media, 13- Electronic and new media, 3-Folk media and 1-others.

Based on the overall and activity wise use of Health Communication Strategies by the ASHAs, categorisation was done as follows:

Use of Health Communication Strategies	No. of Items	Minimum obtainable score	Maximum obtainable score
Overall	155	0	155
Home visit	31	0	31
Planning and celebrating VHND (*Mamta day*)	31	0	31
Visit Health Facilitates	31	0	31
Village Health and Sanitation Committee Meeting	31	0	31
Keeping and informing about records	31	0	31

2.10.5 Perceived Benefits of Health Communication Strategies

For the purpose of checking the Perceived Benefits of Health Communication Strategies by ASHAs, a rating scale was developed. Review of literature, findings of the feasibility study and researcher's personal on field observations helped in framing of statements

under this section. The Five-point scoring pattern was used for the rating of total 23 statements, which is described in following table:

The extent of Perceived Benefits	Score	No. of Items	Minimum obtainable score	Maximum obtainable score
Least beneficial	1	23	23	115
Somewhat beneficial	2			
Beneficial	3			
More beneficial	4			
Extremely beneficial	5			

The Maximum Obtainable score was 115 and Minimum obtainable score was 23 in the section namely 'Perceived benefits of Health Communication Strategies'. Therefore, categorisation was done by considering the range and basis given in the below table.

Variable	Range	Categorisation
Perceived Benefits of Health Communication Strategies	96 and above	Extremely beneficial
	76-95	Moderately beneficial
	75 and below	Least beneficial

Further, to find out the overall and item wise perceived benefits by ASHAs, intensity indices were measured. Following is the categorisation of Intensity Indices:

The extent of Perceived Benefits	Range of Intensity Indices
Extremely beneficial	4.2-4.7
Moderately beneficial	3.6-4.1
Least beneficial	3.0-3.5

2.10.6 Barriers related to Health Communication Strategies

A five-point rating scale was developed to measure the barriers related to Health Communication Strategies expressed by the ASHAs. For this rigorous review of literature and findings of the feasibility study were used as reference for preparing tool covering five aspects of Health communication Strategies *viz.* their Features, availability and accessibility, characteristics of authorities, beneficiaries and personal. In total 29 statements were prepared for which following Five-point scoring pattern was used:

Extent of Barriers	Score	No. of Items	Minimum Obtainable Score	Maximum Obtainable Score
Least barrier	1	29	29	145
Somewhat barrier	2			
Barrier	3			
More barrier	4			
Extreme barrier	5			

In this section, Maximum Obtainable score was 145 and Minimum obtainable score was 29. The following table guided the researcher for categorisation of barriers expressed by the ASHAs for Health Communication Strategies.

Variable	Range	Categorisation
Barriers of Health Communication Strategies concerning selected aspects	118 and above	Extreme level of barrier
	71-117	Moderate level of barrier
	70 and below	Least level of barrier

To find out overall and item wise Barriers faced by the ASHAs, intensity indices were measures. Following is the categorisation of Intensity Indices:

Extent of Barriers	Range of Intensity Indices
Extreme level of barrier	2.9-4.0
Moderate level of barrier	1.7-2.8
Least level of barrier	0.5-1.6

2.10.7 Need of Additional Health Communication Strategies

A classified checklist of Health Communication Strategies was used to assess the need of additional Health Communication Strategies for selected work, wherein total 31 Health Communication Strategies were given in four categories viz, 14- Print and graphic media, 13- Electronic and new media, 3-Folk media and 1-others.

Need for Additional Health Communication Strategies	No. of Items	Minimum Obtainable Score	Maximum Obtainable Score
Overall	155	0	155
Home visit	31	0	31
Planning and celebrating VHND (*Mamta day*)	31	0	31
Visit Health Facilitates	31	0	31

Village Health and Sanitation Committee Meeting	31	0	31
Keeping and informing about records	31	0	31

Based on the need of additional Health Communication Strategies expressed by the respondents for each work, categorisation was done as follows:

Need for Additional Health Communication Strategies	No. of Items	Minimum Obtainable Score	Maximum Obtainable Score
Overall	155	0	155
Home visit	31	0	31
Planning and celebrating VHND (*Mamta day*)	31	0	31
Visit Health Facilitates	31	0	31
Village Health and Sanitation Committee Meeting	31	0	31
Keeping and informing about records	31	0	31

2.11 Plan of Statistical analysis of the Data

For analysing the quantitative data, various appropriate and meaningful statistical measures were planned for the purpose of data analysis.

Table:4 Plan of Statistical Analysis

Purpose	Statistical Measures
Personal Information	Frequencies and Percentages
Work-Related information	Frequencies and Percentages
Media Use	Frequencies and Percentages
Occupational skills	Frequencies and Percentages
Training Received	Frequencies and Percentages
Knowledge about Health Communication strategies	Frequencies and Percentages
Provision of Health Communication Strategies	Frequencies and Percentages
Use of Health Communication Strategies	Frequencies and Percentages T-test, ANOVA, Tukey's HSD
Perceived Benefits of Health Communication Strategies	Frequencies and Percentages T-test, ANOVA,

	Tukey's HSD
	Intensity Indices
Barriers related to Health Communication Strategies	Frequencies and Percentages
	T-test, ANOVA,
	Tukey's HSD
	Intensity Indices
Need of Additional Health Communication Strategies	Frequencies and Percentages
	T-test, ANOVA,
	Tukey's HSD

B) Methodology for FGDs and In-Depth Interview

FGDs and In-Depth Interview facilitated researcher to gather in-depth, comprehensive and descriptive responses from the groups of respondents. These helped in consolidating the complete scenario of the phenomena under study.

212 Sampling unit

To fulfil requirements of FGDs; ASHAs, ASHA Facilitators and Female Health Workers and for In-Depth Interview, Chief District Health Officer were identified as Sampling units.

2.13 Sampling frame

1102 ASHAs, 118 ASHA Facilitators, 306 Female Health Workers constitute the sampling frame for FGDs in present investigation. Each district has one CDHO, so the officer became sample cum sample frame.

2.14 Sample size and selection technique

From each sample frames the selection of sample was done purposively based the permission and appointment given by the respective Block Health Officer and Chief District Health Officer. The BHOs helped researcher in the process of sample selection. To fulfil the requirements of present research data following criteria were shared with the respective BHO in advance:

- Those who are vocal and able to communicate their own ideas, viewpoints and actively participate in the FGD.
- Those having understanding of Village Healthcare system and therefore can express health concerns for the same.

- Those who can deliberate and discuss on selected aspects of Health Communication Strategies *viz.* provision, use, benefits, barriers and needs.
- Those with personal willingness and interest in participation in FGD.

Table: 5 Distribution of Participants in FGDs

Samples	Chhotaudepur	Bodeli	Kavant	Nasvadi	Pavijetpur	Sankheda	Total
ASHAs	10	15	8	9	12	20	74
ASHA Facilitators	5	3	5	5	3	10	31
Female Health Workers	5	4	4	5	6	10	34

One In-Depth Interview was conducted with Chie District Health Officer.

2.15 Research tools for FGDs and In-Depth Interview

Following tools were developed by the researcher for specific participant groups to efficiently elicit qualitative data.

Objective	Participants	Tools
Profile, Provision, Use, Perceived benefits, Barriers, Need of Additional HCS	ASHAs	FGD theme guide (Appendix-5)
Provision, Use, Perceived benefits, Barriers, Need of Additional HCS	ASHA Facilitators and Female Health Workers	FGD theme guide (Appendix-6)
Existing health facilities, Process of Health Communication (Planning, executing, monitoring and recommendation for future HCS)	Chief District Health Officer	Proforma & In-Depth Interview Schedule (Appendix-7)

2.16 Process for conducting FGDs and In-Depth Interview

2.16.1 Conducting FGDs

AS per the appointment given by the BHO, investigator coordinated with the group members. The BHOs were kind enough to facilitate in fixing up the time and venue to conduct the Focus Group Discussions.

In each from six blocks, two FGDs were conducted *i.e.* one with the group of ASHAs and one with the combined groups of ASHA Facilitators and Female Health Workers. Therefore, in sum 12 FGDs were conducted in the whole of the District.

The BHOs of Chhotaudepur, Kawant and Naswadi felt it convenient to hold FGDs at their respective Block Health Offices for all groups. In two blocks namely Bodeli and Pavi Jetpur the FGDs were organised at Tadkachala and Bar PHCs respectively for all groups (ASHAS, ASHA Facilitators and FHWs). Whereas Sankheda BHO planned FGD with ASHAs at Bhatpur PHC and with ASHA Facilitators and FHWs it was held at Jalaram Mandir, Sankheda. Holding and facilitating the FGD was an enriching experience. Proper sitting, light, ventilation; documentation facilities like video camera, audio recorder and consent cum attendance sheet were arranged at the venue beforehand. The researcher herself facilitated the group discussion.

All the groups were familiarized properly to the subject of research and purpose of holding focus group discussion. They were also explained about the basic rules/decorum of FGD like, everyone has an equal chance to speak/share, respecting one another's viewpoints/feelings/ideas, not to cut/interrupt while any participant is speaking *etc.* Consent was sought from the interested Group members. Interestingly there was not a single person who did not give her consent, actually there were more members who were enthusiastically present then expected by the Investigator. Therefore, they all were involved in FGDs. Then facilitator, initiated discussion by putting up questions/points of discussion referring to the Theme-guides prepared for each set of groups. FGDs with ASHAs took almost 35-55 mins, whereas FGD with the combined group of ASHA Facilitators and FHWs lasted for 20-35 mins.

2.16.2 Conducting an In-depth Interview

An appointment was taken well in advance for arranging an in-depth interview with the Chief District Health Officer. It took almost 1 hour and 10 mins to elicit all the answers

as planned under the interview schedule. Interview was documented electronically as well as manually to keep record and reference for data analysis. FGDs and In-depth Interview were done personally by the researcher during March 2019-April 2019.

2.17 Content Analysis and Interpretation of Data

As a first step of analysis of FGDs and in-depth interview, the researcher prepared transcripts from recordings and running notes. Verbatims were read-reread for enlisting trending sub-themes under themes based on the objectives of the study. Then after, comparative tables of sub-themes under each theme were prepared. Responses of the participants are reported in the finding and discussion chapter in the boxes containing verbatims according to themes and sub-themes derived.

2.18 Ethical aspects of the Research

During the course of the study, the investigator had considered and followed necessary ethical measures. First and foremost, important permission for data collection was taken from State Health and Family Welfare Department, Gandhinagar and Chief District Health Officer, Chhotaudepur.

Moreover, all the tools used under both qualitative and quantitative approaches were validated by in total 13 subject experts in their field of knowledge.

The investigator had taken written consent from all respondents before executing questionnaire, Focus-Group Discussion and Interview.

FINDINGS

Major findings:

3.1 Profile of Existing Health Facilities

Table: 5 Profile of Existing Health Facilities

Sr.No.	Indicators	Data
1	Total number of PHCs	45
2	Number of 24*7 Primary Health Center	22
3	Total number of CHCs	12
4	Total Number of Sub Centers	310
5	Number of District Hospital	1
6	Number of Ayurvedic Dispensary	0
7	Number of Operational Anganwadis	1182
8	Number of Anganwadis having its own Building	1182
9	adolescent health clinic	01
10	Number of NBCC (All delivery points facilities)	57
11	NRCs/CMTCs	01 NRC 7 CMTC

Process of Health Communication:

Planning

- State IEC team and others (Govt Depts., NGOs and consultants) were involved in planning.

Execution/receiving at District

- District Panchayat Office, as per their fixed rates takes prints whenever soft copies are not received from the state and for scrolling messages on local cable TV

Distribution system in District

- Distribution and supply chain-management upto PHC, community and front line health workers was managed from the District Panchayat Office.
- Stock registers were maintained at all level but not uniformly.

Monitoring

- Not done systematically. CDHO reported about Occasional monitoring.

3.2 Profile of ASHAs:

3.2.1 Variables under study:

- Little more than half (55.2%) of ASHAs belonged to young age, had received education up to secondary level (46.6%), having high media use (40.2%), possessing excellent occupational skills (47.5%) and had medium knowledge about Health Communication Strategies (56.75%).
- Very high majority (89.6%) of the ASHAs had received complete training *i.e.* all seven modules and refresher course; 64.4 per cent of the ASHAs possessed more work experience as an ASHA under NHM.

3.2.2 Personal information of the ASHAs:

- Almost all the ASHAs found themselves proficient in Gujarati language and majority were also proficient in Hindi language.
- Very high majority (91.1%) were married.
- Majority (68.4%) ASHAs belonged to Schedule Tribe caste.
- Total monthly family income for majority of the ASHAs (66.3%) were comparative higher than their counterparts.
- Little more than half *i.e.* 53.1 per cent of the ASHAs had more members in their families.

- Little more than half *i.e.* 56.1 percent of the ASHAs lived in joint family.

3.2.3 Work related information of the ASHAs:

- Very high majority (83.7%) of the ASHAs were assigned one village, where in majority *i.e.* 58.6 per cent and 56.7 per cent of the total ASHAs had to cover comparative small size population and a less number of families respectively for their work.
- Almost three fourth of the ASHAs visited to PHC and CHC for medical advice, check-up of ANC mothers and general patients.
- A Very high majority (90.1%) of the ASHAs approached to CHC followed by PHC by 76.1 per cent for conducting delivery of registered pregnant women.
- A Very high majority (92.3%) of the ASHAs used 108-ambulace followed by majority (65.2%) ASHAs reached to her destination by walking on foot.

During FGDs it was expressed that ASHAs have found improvements both personally and professionally. They have acquired skills and knowledge, which have empowered them to work efficiently in their allotted village area. At personal front ASHAs have started feeling empowered in terms of financial, social, family and health aspects.

ASHAs have reported significant change in perspectives of family, community and government health organisations towards themselves. Since majority of the ASHAs have joined duties for more than eight years, they have established their positive image amongst beneficiaries. Their tireless, selfless, constant and dedicated efforts in health care service delivery for community people have earned them respect, trust and credibility. It was reported by the ASHAs that Government offices and other NGOs now rely upon ASHAs for smooth rollout of their activities and programmes in communities.

3.3 Sources of Information:

- More than half (58.3%) of the ASHAs had more sources of information for seeking health and health programmes related information.

3.4 Provision of Health Communication Strategies:

3.4.1 Provision of Health Communication Strategies to ASHAs:

- Little more than half (51.2%) of the ASHAs were provided with less number of Health Communication Strategies which can be used for performing their duties.

- Very high majority of ASHAs, 93.6 per cent, 92.9 per cent and 87.7 per cent reported that they were provided with *Mamta card* (health card), ASHA diary and Chart/posters respectively.
- High majority of ASHAs were provided with Registers (80.1%) and with Leaflets (73.9%) too.

3.4.2 Provision of Health Communication Strategies to ASHAs:

- ASHA diary, *Mamta* Card , Flipbook on *"Janani Suraksha Yojana"*, Chart/Posters on anaemia, ante-natal and post-natal care, breast feeding, new born care at home, sign and symptoms of high-risk baby *etc.* for explaining to new mothers and their families.
- Chart/posters on smoking-tobacco addiction, leprosy *etc.* were provided to the ASHAs.
- ASHAs mentioned about wall paintings and display of chart/posters at public places and Aanganwadi respectively.

3.4.3 Provision of Health Communication Strategies to ASHA Facilitators:

- ASHA Facilitators mentioned provision of flipbook on pregnancy and vaccination; posters on cancer; posters and flipbooks on content related to mother and child health care; small size posters for leprosy.

3.4.4 Provision of Health Communication Strategies to Female Health Worker:

- FHWs were provided with Media-mix consisting; graphic media like chart, poster, flipbook, flipcharts and booklets on specific diseases, electronic media like SATCOM, PA system for announcements, mobile phones-TeCHOmobile, with pre-installed presentations *etc.*

3.5 Use of Health Communication Strategies:

3.5.1 Use of Health Communication Strategies by the ASHAs:

- Overall 41.7 per cent of the ASHAs used more number of Health Communication Strategies.
- Overall ASHAs having more work experience, excellent occupational skills and belonging to Pavi Jetpur used more number of Health Communication Strategies than their counterparts.

3.5.2 Use of HCS during Home visit:

- Little more than half (56.1%) of the ASHAs used less number of Health Communication Strategies during Home visit.
- High majority *i.e.* 89.3 per cent and 83.4 per cent of the selected ASHAs used *Mamta* Card (Health card) and ASHA diary respectively. Register (69.9%), Chart/Poster (66.6%) and Leaflets (61.7%) were also used by the respondents.
- There were significant differences among the ASHAs with their work experience and belonging to different blocks for their use of Health Communication Strategies during Home visit. The ASHAs having more work experience and from Pavi Jetpur used significantly more Health Communication Strategies then those belonging to Bodeli, Naswadi and Kawant.

3.5.3 Use of Health Communication Strategies during planning and celebrating VHND (Mamta day)

- Overall higher use of Health Communication Strategies was expressed by little higher than half (51.5%) of the ASHAs during *Mamta day*.
- High majority of the selected ASHAs used *Mamta* card (health card) (94.8%), ASHA diary (90.8%) and register (86.8%) followed by chart/poster (76.7%), mobile phones (62.6%) during planning and celebration of *Mamta* day.
- The ASHAs having more work experience used significantly more number of Health Communication Strategies than their counterparts with less work experience.
- Significant differences were seen in use of Health Communication Strategies by the ASHAs according to their blocks and occupational skills. The mean use of HCS for planning and celebrating VHND by ASHAs from Pavi Jetpur was significantly higher than those from Bodeli, Naswadi and Kawant.

3.5.4 Use of Health Communication Strategies for Visit to Health Facilities:

- Higher per cent of the ASHAs (63.8%) used less number of media.
- High majority *i.e.* 82.8 per cent, 78.5 per cent, 74.5 per cent, 73.6 per cent and 68.7 per cent of the selected ASHAs used ASHA diary, register, mobile phone, *Mamta* Card (Health card) and chart/poster respectively.
- Significant differences were revealed related to use of HCS for 'Visit to Health facilities' by ASHAs with respect to their blocks and knowledge regarding HCS. The

ASHAs belonging to Pavi Jetpur used significantly more Health Communication Strategies than those from Bodeli and Sankheda and similarly the ASHAs with medium knowledge used more Health Communication Strategies their counterpart with High Knowledge.

3.5.5 Use of Health Communication Strategies for VHSC meeting

- Higher per cent of the ASHAs (62.0%) used less number of Health Communication Strategies for VHSC meetings.
- High majority of the ASHAs used register (85.9%), ASHA diary (67.2%), mobile phone (70.6%), chart/poster (57.1%) and *Mamta* card (47.2%) for VHSC meeting.

3.5.6 Use of Health Communication Strategies for keeping and informing about records

- Majority (62.9%) of the ASHAs used less number of Health Communication strategies.
- High majority of the ASHAs used register (91.4%), ASHA diary (88.9%), mobile phones (81.6%), *Mamta* Card (56.1%) and CUG card (39.3%) for maintaining and informing about records and birth-death details of community area.
- Significant differences were observed in ASHAs according to their blocks and occupational skills in use of Health Communication Strategies. The ASHAs belonging to Naswadi possessing excellent occupational skills used more Health Communication Strategies than those from Chhotaudepur, Bodeli and Kawant blocks and having moderate level of occupational skills.

Qualitative and Quantitative findings revealed that ASHAs used *Mamta* card, ASHA Diary and registers for most of their duties.

3.5.7 Use of Health Communication Strategies by the ASHA Facilitator:

- During home visits and on Village Health and Nutrition Day, they used *Mamta* card posters/charts, banners, flip book and their own experiences to explain beneficiaries, their families to educate them regarding high risk signs and symptoms of pregnancy through comparative pictures.

3.5.8 Use of Health Communication Strategies by the Female Health Workers:

- They used loud speakers on polio day, Posters/ Charts, banners, samples *etc.* on VHND-*Mamta* day, *Mamta* card during home visit and counselling session at *Mamta* day.

- Most of the time, TeCHOmobile was used for data entry, maintaining work schedule and showing videos to beneficiaries.
- FHWs organized presentations on health care, mensuration and related hygiene, nutrition etc under 'School Health Programme'.

3.6 Perceived Benefits of Health Communication Strategies:

3.6.1 Perceived Benefits of Health Communication Strategies expressed by the ASHA:

- More than half *i.e.* 60.4 per cent of the ASHAs felt that Health Communication Strategies were extremely beneficial.
- The ASHAs belonging to Chota Udepur with high level of occupational skills expressed that the Health Communication Strategies were highly beneficial, than those from Sankheda, Bodeli and with moderate and poor occupational skills.
- Very high intensity indices were observed for the majority of the items, Related to Health Communication Strategies like;
    - *Help in rapport building,*
    - *Help in providing Social recognition,*
    - *providing scope for repetition/reminders for adoption of behaviour/innovation amongst beneficiaries*
    - *assist in promoting services and innovations amongst beneficiaries.*

3.6.2 Perceived Benefits of Health Communication Strategies expressed by the ASHA Facilitators:

- The ASHA Facilitators felt that pictures in *Mamta* card and other graphic media as well as in TeCHOmobile were very much effective for creating awareness and during counselling.
- Mobile phone was reported as an effective means to stay connected, providing information and clarifying doubts by the ASHA Facilitators.

3.6.3 Perceived Benefits of Health Communication Strategies expressed by the Female Health Workers:

- Female Health Workers identified, electronic media like Audio-Video Presentations on large screen for large gatherings and video clips on TeCHOmobiles to be highly effective.
- TeCHOmobiles were found very much useful in establishing contacts, data entry and retrieval, maintaining work schedule *etc.*

3.7 Barriers related to Health Communication Strategies:

3.7.1 Barriers related to Health Communication Strategies felt by the ASHAs:

- Majority *i.e.* 73.6 per cent of the ASHAs faced moderate barriers related to selected aspects of Health Communication Strategies.
- Significant differences were observed in ASHAs according to their blocks, occupational skills, knowledge regarding Health Communication Strategies and Media use for 'Barriers related to Health Communication Strategies'.
- ASHAs belonging to Bodeli, having excellent occupational skills, with low knowledge about Health Communication Strategies and average media use expressed more barriers than their counterparts from Sankheda and Pavi Jetpur, having moderate occupational skills, with high knowledge and high media use.
- High intensity indices were found for the barriers related to 'Features of Health Communication Strategies'. The ASHAs faced barriers related to visual representation, quantity, weight (heaviness), production quality, coherence with other strategies, content and language/local terminology.
- Barriers related to 'Availability and accessibility' of Health Communication Strategies were faced at extreme level. The high intensity indices were found for all the items in this section *viz.*, poor condition of infrastructure resources, timely unavailability, lack of storage facilities, timely in-accessibility, insufficient infrastructure hindering effective use of Health Communication Strategies
- The ASHAs expressed moderate level of barriers with regards to 'support from authorities for use of Health Communication Strategies' *viz.*, absence of motivation, absence of monitoring and evaluation, lack of interest of seniors and indifferent attitude of seniors towards use of Health Communication Strategies while performing the prescribed duties.

- The barriers related to 'characteristics of beneficiaries' have affected use of Health Communication Strategies at extreme level to the selected ASHAs. Poor response, heterogeneity amongst beneficiaries and their indifferent attitude towards use of Health Communication Strategies were reported as extreme level of barriers by the ASHAs.
- The selected ASHAs faced extreme level of barriers at 'Personal level' due to her own characteristics like, absence of training for preparation, use and storage of Health Communication Strategies, lack of time due to overburden of work.

ASHAs during FGDs expressed that they felt barriers related to two major aspects *i.e.* **accessibility and availability of Health Communication Strategies** and **characteristics of beneficiaries for use of Health Communication Strategies**.

3.7.2 Barriers related to Health Communication Strategies felt by the ASHA Facilitators:

- Thematic analysis of the responses of ASHA facilitators emerged two trends of findings viz, barriers related to accessibility and availability of Health Communication Strategies like and characteristics of beneficiaries for use of Health Communication Strategies.
- Majority of ASHA facilitators expressed that they faced problems related to power-cut off and poor mobile network connectivity. Since they were not provided with ASHA Diary, registers and not even TeCHOmobile, they faced difficulty in performing their roles during home visit, record keeping and sharing them with FHWs.
- They also expressed problems related to reluctant attitude of beneficiaries towards health benefits.

3.7.3 Barriers related to Health Communication Strategies felt by the Female Health Workers:

- FHWs mentioned problems related to data entry and its management. There is repetition of details at three places *i.e.* register, E-*Mamta* portal and TeCHOmobiles and technical problem of data entry for family migrants.
- Barriers regarding beneficiaries they expressed that, some people in the village were superstitious and had their religious beliefs which did not allow beneficiaries to seek health benefits.

3.8 Needs of additional Health Communication Strategies:

3.8.1 Needs of additional Health Communication Strategies expressed by the ASHAs:

- High majority (72.4%) of the ASHAs were in need of training on 'Use of Health Communication Strategies'
- Nearly half of the ASHAs (47.2%) expressed their need for Health Communication Strategies for planning and celebration of Village Health and Nutrition Day (VHND) popularly known as *Mamta day* followed by other activities.
- Overall two fifth of the ASHAs *i.e.*, (40.5%) expressed that they were in need of more number of Health Communication Strategies, which can facilitate their work.

3.8.2 Need of additional Health Communication Strategies for Home visit

- High majority of the ASHAs *i.e.* 85.3 per cent and 81.0 per cent, expressed their need for ASHA diary and Registers respectively. Moreover, among Graphic and Print media category, it was reported that majority (65.6 % and 61.3%) of ASHAs were in need of *Mamta* card (Health card) and chart/posters respectively. Among electronic and new media, mobile and CUG sim card were needed by the majority *i.e.* 71.2 per cent and 61.3 per cent of selected ASHAs.
- Highly significant mean differences amongst categories with respect to the additional need of additional Health Communication Strategies expressed by the ASHAs from Sankheda needed more HCS than those from Pavi Jetpur
- Similarly, ASHAs with high occupational skills were in need of significantly more Health Communication strategies as compared to the ASHAs with moderate level of occupational skills for performing their duties during Home visit.

3.8.3 Need of additional Health Communication Strategies for Planning and celebrating VHND

- Higher per cent (61.3%) of ASHAs needed less HCS.
- Among graphic and print media, majority of the ASHAs needed ASHA diary (82.5%), Register (78.2%), *Mamta* card (Health card) (77.0%) and Chart/Poster (69.0%) additionally. Among electronic media, 62.00 per cent and 53.70 per cent of the ASHAs expressed their need for mobile phones and CUG cards respectively.

- Significant differences were seen for the need of additional Health Communication Strategies for 'Planning and Celebrating VHND' by the ASHAs according to their block and occupational skills.
- The ASHAs from Naswadi block needed more Health Communication Strategies than Chhotaudepur, Sankeda, Pavi Jetpur and Kawant.
- ASHAs with high occupational skills needed more Health Communication Strategies as compared to the ASHAs with moderate level of occupational skills for performing their duties for planning and executing VHND.

3.8.4 Need of additional Health Communication Strategies for Visit to Health Facilities

- Overall, majority of the ASHAs (65.6%) needed less number of Health Communication Strategies for planning, coordinating and making any visit to health facilities.
- Higher per cent of the ASHAs needed Register (72.4%), ASHA Diary (71.5%), *Mamta* Card (59.2%), Mobile phone (58.9%) and chart/poster (54.3%).
- Significant differences were observed in ASHAs for need of additional Health Communication Strategies for 'Visit to Health facilities' with respect to their blocks, educational qualification, occupational skills and knowledge regarding Health Communication Strategies.
- The ASHAs from Naswadi had significantly high demand than their counter parts from all the blocks *i.e.* Chhotaudepur, Bodeli, Pavi Jetpur, Kawant and Sankheda.
- ASHAs who studied up to secondary school, having excellent occupational skills and having low knowledge about Health Communication Strategies had expressed more need than those who studied up to higher education, with moderate occupational skills and high knowledge of Health Communication Strategies.

3.8.5 Need of additional Health Communication Strategies for Village Health Sanitation Committee Meeting

- Fifty-eight per cent of the ASHAs needed less number of Health Communication Strategies for VHSC meeting.
- Highest need reported by the ASHAs, was registers (73.0%), followed by ASHA diary (66.3%), Mobile (59.8%), Chart/poster (58.6%) and Banner (55.8%).
- Significant differences were observed in ASHAs according to their blocks, occupational skills and knowledge regarding Health Communication Strategies for need of additional Health Communication Strategies for 'VHSC meeting'.

- The ASHAs belonging to Naswadi, having excellent occupational skills and with low level of knowledge regarding Health Communication Strategies had more need of Health Communication Strategies than those belonging to Chhotaudepur, Sankheda, Pavi Jetpur, Kawant and Bodeli, having moderate occupational skills with medium and high knowledge.

3.8.6 Need of additional Health Communication Strategies during Keeping and informing about records

- Little more than half (58%) of the ASHAs needed less number of Health Communication Strategies for keeping and informing about records.
- Similar high majority *i.e.* 81 per cent of the ASHAs needed registers and ASHA diary followed by 66.6 per cent mobile phones additionally.
- The ASHAs from Sankheda needed highly significant number of Health Communication Strategies than those from Chhotaudepur, Kawant and Naswadi for their work related to maintaining and giving information about health records of their area.

FGD data majorly focused upon improvement in current Health Communication Strategies, need of additional media and training related requirements expressed by the ASHAs for performing their assigned roles.

3.8.7 Needs of additional Health Communication Strategies expressed by the ASHA Facilitators:

- ASHA Facilitators were found to have least provision; therefore, they were in extreme need of ASHA kit, mobile phone and also training for folk media.
- Some of the Facilitators suggested to provide more of graphic media like posters and flipbooks to ASHAs.

3.8.8 Needs of additional Health Communication Strategies expressed by the Female Health Workers:

- Most of the FHWs recommended the review of TeCHOsoftware and system of record maintenance since they need to do lot of duplication.

- Most of FHWs strongly suggested that TeCHOmobiles should be provided to ASHAs and ASHA facilitators for smooth functioning of data management, better connectivity and effective use on field for showing video and other posters in it.
- Majority mentioned that they need projective facilities like LCD with screen need to be established at PHC and Anganwadi level for arranging video show for beneficiaries on *Mamta* day and addressing group off villagers.

CONCLUSION AND RECOMMENDATION:

Chhotaudepur district received various Health Communication Strategies from the State IEC department which then further distributed, displayed and used by staff and grass root level functionaries (ASHA, ASHA Facilitators, Female Health Worker, Anaganwadi Worker).

It can be inferred that the comparatively large group of ASHAs have higher number of sources of information but are provided with less number of Health Communication Strategies and further they use still lesser number of Health Communication Strategies and reflected less need for additional Health Communication Strategies.

ASHAs, ASHA Facilitators and Female Health Workers had perceived that Health Communication Strategies are highly beneficial and overall, they have reported barriers to moderate level.

It can be derived from findings that Occupational skills, Training under NHM, knowledge about HCS and blocks had significant differences in majority of the selected aspects.

Since NHM is mission mode umbrella programme aiming 'Universal Coverage of Health'; communication component should be devised and encashed at utmost.

There existed lack of continuity and coherence in designing and use of HCS. As NHM caters to all health programmes and diseases, there requires serious efforts towards coherence, continuity and convergence in HCS.

Communication is an intergral component of NHM, it can connect, create awareness, mobilise people and assist in managing information and data.

Health promotion and health education through strategic communication can play significant role in desired behaviour change and promoting health benefits.

Therefore, policy planners should pay equal attention to planning, designing, implementation and monitoring of strategic health communication efforts as to promote prevention of diseases rather than only on curative and service delivery aspects of health programme.

CDHO during his interview also reflected his concern for quality of health messages. He reported that most of the time quality of communication is neglected because of more focus on target-based quantity (data) driven health programmes.

Indian societies have deep rooted culture and tradition touching all the aspects of human life. Culture specific and culture centric strategic communication can play pivotal role

in mass mobilization and adaptation of better and healthy living practices. ASHAs, AFs, FHWs mentioned that tribal people of Chhotaudepur adopt fast when they are exposed to real life examples and comparative situations in their own habitat. This denotes characteristics of social learning theory and Socio-Ecological model. People learn and adopt fast what they see in others, in their surrounding and they also need social approval as described in Socio-Ecological model.

Although health problems remain the same in majority of parts of the state. However, people will recognize and adopt easily when they can relate communication message with themselves. Therefore, it is strongly recommended that each and every Health Communication plan need to be local people specific and their culture sensitive. This can be achieved with local representation through local terminology in message, graphic/pictures of their own society and culture in all the communication strategies be it graphic/print, electronic, folk forms used during interpersonal, group and mass media activities.

The demand for folk media was reported by all selected participants of the study (*i.e.* ASHAs, ASHA facilitators, Female Health Workers and CDHO) for promotion of Healthy behaviours and health services among beneficiaries of tribal district Chhotaudepur. As it can directly connect, question satire way and emotionally influence adoption of better health practices.

Findings highlighted demand for smart phone from ASHAs and ASHA facilitators. The reason may be that they have observed interest of beneficiaries in new media and technologies and ultimately harnessing good results for behavior change.

Therefore, it is strongly recommended to the NHM-state level and district level officials and other agencies involved in planning and designing of Health Communication to carryout systematic evaluation of Techno Mobile, its use, benefits and barriers so that this new technology can be harnessed for its utmost potential in achieving health targets and thus ultimately the healthy nation.

According to ASHAs guidelines, the high majority the selected ASHAs have been trained under NHM. However, training concentrates around curative aspects of diseases, MCH, vaccination *etc.* whereas preventive aspects of Health programmes i.e Health Communication is not included in training which should also be part of the training sessions.

It implies that policy planners along with Health communication experts should outline and implement training on use, types, importance of HCs in National Health Mission

for all staff and frontline functionaries who directly deal with beneficiaries so as to achieve goals of health promotion and service delivery.

Findings highlighted that ASHAs, ASHA facilitators and female health workers use variety of HCs during village health and Nutrition Day, which is monthly regular event in a village. This opportunity of interacting with majority of beneficiaries (ANC, PNC, Children, Adolescent, Fertile Couples *etc.*) should be utilized optimally by using multiple approaches of Health Communication. *Mamta* Day event should be publicized and carryout more strategically by the Health communication planners. They should provide more facilities like TV, Projector, Loud Speaker, Some stage/Platform, Display boards *etc.* and should produce need-based media for counselling group, meeting, mass mobilization, take home materials/literature *etc.* keeping in mind the local beneficiaries. Moreover, in planning and designing of communication strategies, grass root level functionaries and volunteers (ASHAs, ASHA facilitators & Female Health Workers Block and District level officers) should be involved since their on-field experiences with their beneficiaries are very imperative in successful evidence-based roll-out of Health Communication efforts.

Therefore, their responses essentially considered while planning of HCs. This is also practical since front line Health functionaries are ultimate users of HCs for creating awareness, providing Health Education, Mobilisation, promoting Health benefits/services and establishing a link between all stakeholders associated with National Health Mission. They should be provided assistance, support and motivation to organise and conduct Health promotion programmes through strategic communication. State level policy planners and district administrators should be sensitised towards importance of Health Communication strategies and its urgent need to keep a check on a material resources, its stock and monitor supply chain management on field use and its impact evaluation for documenting success stories.

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